



New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
Physician Assistant Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45035
Newark, New Jersey 07101
(973) 504-6580

Verification of Supervision/Employment

Note: Please print information on this form.

As of _____, _____, License #25 MP _____
Date Physician Assistant

will be engaging in practice as a Physician Assistant under my direct Supervision.

Print name of Supervising Physician Field of Practice N.J. Physician License Number

Name of Practice/Facility Facility type (circle one):
Inpatient or Outpatient Telephone number (include area code)

Street address City State ZIP code

Employer (if different from above)

Street address City State ZIP code

In my absence, a plenary licensed Physician Designee will provide supervision.

Supervising Physician's Affidavit

I, the supervising physician, have read the statute, N.J.S.A. 45:9-27.10 et seq., and accept the responsibility for its implementation, and I certify that the forgoing statements made by me are true. I am aware that if any of the statements made by me are willfully false, I am subject to disciplinary action.

I also verify that I am a plenary licensed physician in the State of New Jersey and that my license is in good standing.

Print Supervising Physician's name Signature of Supervising Physician Date

Print Employer's name Signature of Employer Date

Print Physician Assistant's name Signature of Physician Assistant Date